QUARTERLY CONTRACT MONITORING REPORT (QCMR)
CLIENT MOVEMENT REPORT
INTEGRATED CASE MANAGEMENT SERVICES

USTF PROJECT CODE:	**REPORTING QUARTER: (CHECK ONE):**
NAME OF AGENCY:	**JULY 1 TO SEPTEMBER 30** **1** ☐
NAME OF PROGRAM:	**OCTOBER 1 TO DECEMBER 31** **2** ☐
PERSON COMPLETING FORM/PHONE #:	**JANUARY 1 TO MARCH 31** **3** ☐
DATE SUBMITTED:	**APRIL 1 TO JUNE 30** **4** ☐

CHECK AGENCY REPORTING QUARTER:	**1** ☐	**2** ☐	**3** ☐	**4** ☐

1.	2.	3.	4.	5.	6.
Beginning Active Caseload (First Day of Quarter)	**New Enrollees to Program Element During Qtr.**	**Transfers to Program Element During Quarter**	**Transfers From Program Element During Qtr.**	**Terminations From Program Element During Qtr.**	**Ending Active Caseload (Last Day of Quarter)**

TARGET GROUPS		**7. Number of Target Group Members:**	
		NEW ENROLLEES	**TRANSFERS**
7A.	Clients who were Discharged from State Hospitals and Enrolled in this Program Within 30 Days of Discharge.		
7B.	Clients who were Discharged from County Hospitals and Enrolled in this Program Within 30 Days of Discharge.		
7C.	Clients who were Discharged from a Short-Term Care Facility/Involuntary Psychiatric Unit and Enrolled in this Program Within 30 Days of Discharge.		
7D.	Clients who were Discharged from another Hospital and Enrolled in this Program Within 30 Days of Discharge.		

Client Movement Report

BEGINNING ACTIVE CASELOAD: Consist of clients who have had at least one face-to-face contact with your agency in the last 90 days and were active on the last of the previous quarter. **The Beginning Caseload is equal to the Ending Caseload of the previous reporting quarter.**

NEW ENROLLEES: Clients who were newly enrolled in your agency during the reporting quarter and were enrolled in this program element prior to enrollment in any other program element within your agency.

TRANSFERS TO: Refers to clients who are already registered within your agency in another program element, and are being transferred to this program element service.

TRANSFERS FROM: Refers to clients who are registered within your agency in this program element, but for whom this program has ceased to provide services on an ongoing basis and for whom another program element of your agency is going to provide services on an ongoing basis.

TERMINATIONS: Clients who are no longer receiving services at your agency.

ENDING ACTIVE CASELOAD: Is the active caseload on the last day of the reporting quarter. It is calculated in the following manner: **Add #1** (Beginning Active Caseload) **plus #2** (New Enrollees) **plus #3** (Transfers To). **Subtract #4** (Transfers From) and **#5** (Terminations) = **Ending Caseload #6**.

DUPLICATED COUNT OF TARGET GROUP MEMBERS AMONG "NEW ENROLLEES" AND "TRANSFERS TO": Refers to the count of clients who entered this program element within 30 days of their discharge from the hospital. The definitions of "New Enrollees" and "Transfers To" are the same as stated above. Therefore, the number of "New Enrollees" or Transfers To" indicated in categories 7A, 7B, 7C, and 7D, should be the same or less than the number indicated in items #2 and #3 of this form.

7A. **STATE HOSPITAL:** Refers to the states six psychiatric hospitals located in New Jersey only: Greystone Park, Trenton, Ancora, Arthur Brisbane, Hagedorn, and Ann Klein.

7B. **COUNTY HOSPITALS**: Refers to the six county hospitals located in New Jersey only: Essex, Burlington, Camden, Hudson, Bergen, and Union.

7C. **SHORT-TERM CARE FACILITIES:** Refers to inpatient, community-base mental health treatment facilities that provide acute care and assessment services to the mentally ill. The Commissioner, Department of Human Services must designate the facility.

7D. **OTHER HOSPITAL:** Refers to any psychiatric hospital or psychiatric unit within a hospital that is not a State, County or STCF Hospital in New Jersey; include as "Other" any Facility located outside of New Jersey.

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LEVEL OF SERVICE REPORT

INTEGRATED CASE MANAGEMENT SERVICES

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NAME OF AGENCY:	**JULY 1 TO SEPTEMBER 30** 1 ☐
NAME OF PROGRAM:	**OCTOBER 1 TO DECEMBER 31** 2 ☐
PERSON COMPLETING FORM/PHONE #:	**JANUARY 1 TO MARCH 31** 3 ☐
DATE SUBMITTED:	**APRIL 1 TO JUNE 30** 4 ☐

CHECK AGENCY REPORTING QUARTER:	**1** ☐	**2** ☐	**3** ☐	**4** ☐

1. Of the Ending Caseload, how many consumers are:

A. Medicaid/Familycare enrolled ☐ (1A. + 1B. must equal Ending Caseload)

B. Non-Medicaid/Familycare enrolled ☐

2. Number of Face-to-Face Contacts with:

	Individual		Group	
	On-Site	**Off-Site**	**On-Site**	**Off-Site**
A. Clients in State/County Hospital				
B. Clients in the Community				
C. Client's Family:				
D. Collateral Contacts on Behalf of Clients				

3. Aggregate Number of Telephone Hours ☐

4. Of the Total Individual Contacts, how many were provided to individuals who are:

A. Medicaid/Familycare enrolled ☐ **(4A. + 4B. must equal Total Individual Contacts)**

B. Non-Medicaid/Familycare enrolled ☐

5. Of the Total Group Contacts, how many are:

A. Medicaid/Familycare enrolled ☐ **(5A. + 4B. must equal Total Group Contacts)**

B. Non-Medicaid/Familycare enrolled ☐

6. Number of Unsuccessful Attempts at Off-Site Face-to-Face contacts with Community Clients ☐

7. Number of Clients Linked to Own Mental Health Agency ☐

8. Number Linked to Mental Health Agency Not Your Own ☐

9. Number of Clients Linked to Non-Mental Health Providers ☐

INTEGRATED CASE MANAGEMENT SERVICES

A set of counseling interventions provided by trained clinicians to clients living in the community who require non-immediate care that can be delivered on a scheduled basis. Interventions may include individual, group, and family therapy; medication counseling and maintenance, assessment and testing, outreach services, and referral.

FACE-TO-FACE CONTACTS: Refers to direct contact with or on behalf of the consumers for 15 continuous minutes. If a contact exceeds more than 15 continuous minutes, count as multiple contacts. If two staff members simultaneously serve one client, count as one staff contact. If one staff member serves between two and six clients simultaneously, count as one group contact per client (group contacts of seven or more clients by 1 staff member are not reportable). Travel time is to be excluded from overall contact time.

TELEPHONE CONTACTS: Aggregate phone time with or on behalf of the consumer.

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1. Total Clients Served:
(Beginning Caseload + New Enrollees + Transfers In) ____

2. Of the total clients served, most recent Risk of Hospitalization Status:

- **a. Currently in a Psychiatric Hospital Unit** ____
- **b. High Risk** ____
- **c. At Risk** ____
- **d. Low Risk** ____

(The sum of 2a through 2d must equal item1.)

3. Of those currently in a psychiatric hospital unit, type of facility:

- **a. State Hospital** ____
- **b. County Hospital** ____
- **c. Short Term Care Facility** ____
- **d. Other Psychiatric Inpatient** ____

(The sum of 3a through 3d must equal item 2.a)